

**South Carolina Department of Health and Human Services
MEDICAID POLICY TRANSMITTAL
NUMBER 06-03**

May 26, 2006

To: Executive Staff
Regional Administrators
Medicaid Eligibility Supervisors and Workers
State Office Staff

From: Robert M. Kerr, Director

Subject: Long-term Care Eligibility Changes Due to the Deficit Reduction Act (DRA) of 2005

Effective Date: Upon Receipt

The Deficit Reduction Act of 2005 (DRA), signed into law by the President on February 8, 2006, created numerous changes in the eligibility requirements for long-term care services under Medicaid. Long-term care services include Nursing Facility and other vendor payment levels of care as well as Home and Community Based Waiver (HCBW) services. The changes addressed in this transmittal will require eligibility workers to take appropriate action on applications taken on or after January 1, 2006 or February 8, 2006. The changes addressed in this transmittal are:

- Individuals with home equity that exceeds \$500,000 are ineligible for long-term care services.
- The look-back period for all transfers that occur on or after February 8, 2006 is changed.
- The beginning date for periods of ineligibility (penalty periods) for transfers for less than fair market value (FMV) is changed.
- The treatment of consecutive month transfers is changed.
- Partial month penalties will be determined when the amount of a transfer is less than the average private pay rate or there is a remainder after dividing the transfer amount by the private pay rate.
- The definition of undue hardship is changed.
- The treatment of annuities is changed.
- The treatment of promissory notes and loans is changed.
- The treatment of purchase of a life estate is changed.
- The treatment of entrance fees for a Continuing Care Retirement Community or Life Care Community is changed.

The home equity provision applies to all applications or requests for long-term care coverage received on or after January 1, 2006. The changes related to transfer of resources only apply to transfers made on or after February 8, 2006.

I. HOME EQUITY VALUE

Previously, policy exempted the equity of a primary homestead in determining eligibility for Medicaid for nursing facilities or other long-term care services. The definition of a homestead has not changed.

The applicant/beneficiary's portion of equity in a home may not exceed \$500,000 for those individuals applying for Medicaid long-term care services. The change is effective for applications for these services received on or after January 1, 2006.

Home equity and ownership must be verified. If an applicant/beneficiary's equity in their primary home is over \$500,000, they are not eligible for Medicaid under nursing home vendor payment, or HCBW. The applicant/beneficiary may be eligible for other programs that do not include long-term care services.

The home equity policy does not apply in the following conditions:

- the spouse of the applicant/beneficiary is lawfully living in the applicant/beneficiary's home,
- the applicant/beneficiary's child, who is under age 21, is lawfully living in the applicant/beneficiary's home, or
- the applicant/beneficiary's child, who is 21 or over, is blind or permanently and totally disabled and is lawfully living in the applicant/beneficiary's home.

NOTE: Lawfully residing in the home indicates the individual is in the home with the knowledge and consent of the applicant/beneficiary, and is a permanent resident of the home with no other dwelling. The statement of the applicant or Authorized Representative is sufficient verification.

Procedures for Applications Received on or After January 1, 2006

1. If an applicant indicates homestead property, complete a DHHS Form 1255 ME, Verification of Real and Personal Property, and obtain the current assessed value of the property.
2. If the applicant has a spouse, a child under age 21, or a child who is blind or disabled that lawfully lives in the home, exclude the value of the home regardless of value, and continue with the eligibility determination.

3. If the applicant does not meet the criteria in step 2, and the assessed value is equal to or less than \$500,000, exclude the property, and continue with the eligibility determination.
4. If the applicant does not meet the criteria in step 2, and the assessed value exceeds \$500,000, request verification of any mortgages, liens, judgments or other encumbrances that may reduce the equity value of the property.
5. Subtract the reductions from the assessed value of the property. If the remaining equity value is equal to or less than \$500,000, continue with the eligibility determination. If the remaining equity value exceeds \$500,000, deny for long-term care services.
6. Determine eligibility for Medicaid Assistance Only (MAO) benefits.

For applications received before January 1, 2006, homestead property is excluded regardless of value with intent to return home and is not subject to the home equity requirement as long as there is no break in long term care eligibility after January 1, 2006.

A reverse mortgage or home equity loan reduces the equity in the home. Verification of the proceeds of the loan is required. Do not consider the payments to applicant/beneficiary from either type of loan as income. Inform the applicant/beneficiary that proceeds from a reverse mortgage or home equity loan must be spent. Any of the money from that payment that the applicant/beneficiary retains into the following month is a resource, and transfer penalties apply to improper disposition of the assets.

II. TRANSFER OF RESOURCES

Transfers occurring BEFORE February 8, 2006 continue to be governed by the "old" transfer of assets rules (36-months transfer of assets policy). Transfers occurring on or after February 8, 2006 are subject to the DRA rules.

The look-back period for transfers to trusts continues to be 60 months regardless of the date of transfer.

EXAMPLE #1:

Applicant/beneficiary transferred \$40,000 to his daughter on February 15, 2006. On March 3, 2006, he applies for Medicaid vendor payments. He is eligible for assistance beginning March 2006, except for the transfer. Since the transfer occurred after February 8, 2006, the penalty period begins in March, as this is the first month of eligibility.

EXAMPLE #2:

Applicant/beneficiary transferred \$40,000 to his daughter on November 15, 2005. On March 15, 2006, he applies for Medicaid vendor benefits. He is eligible for assistance except for the transfer. Since the transfer occurred prior to February 8, 2006, the penalty is based on the previous rules and the penalty period begins with the month of the transfer or in this example November 2005. Using the private pay rate of \$4,473.68, as of November 2005, the transfer penalty will be 8 months and the first month of eligibility is July 2006. The applicant/beneficiary may be eligible for other programs that do not include long-term care services.

A. Exploring Transfers of Resources

Eligibility workers will continue to conduct 36-month look-backs until February 2009. Beginning February 2009, the start of the look-back period will be February 8, 2006, and will increase month by month until February 2011 when the full 60-month period will be in effect. The start date of the look-back period will then be determined as 60 months before the date of application.

Procedures for Applications Received on or After February 8, 2006

Bank/Financial Accounts

- Request 36 months of statements on each account from the applicant or authorized representative.
- If the applicant or authorized representative is unable to provide all of the requested statements, evaluate the statements presented and determine if they provide a reasonable picture of the applicant's financial situation. At a minimum, a statement for the month of application, the month prior to the month of application, and a statement for the 12th month, 24th month, and 36th month, should be provided for the look-back period. If these exact months are not available, but the information provided is reasonably close, the information should be accepted.
- If the above statements cannot be secured from the applicant/authorized representative, send a DHHS Form 1253 ME, Request for Financial Investigation, to the financial institution requesting the balances for the above months, and a balance for the month with the highest balance within the look-back period.
- Once the information is obtained, the eligibility worker must examine the statements for evidence a transfer may have occurred.
 - The interest paid to date shows a substantial amount, but the current balance does not support payment of that amount of interest

- The balances in the past show substantially higher amounts than is currently in the account
- If a DHHS 1253 has been obtained from the bank, and it shows a substantial balance that is not currently in the account
- If the account shows a substantial withdrawal or withdrawals over a period of time
- If the eligibility worker finds evidence to suspect a transfer may have occurred, the applicant or authorized representative must be questioned to secure an explanation and be asked to provide additional information and documentary evidence as needed.

B. Determining the Sanction Period

1. For transfers occurring on or after February 8, 2006, the beginning date for the period of ineligibility is the first day of the month in which the transfer occurred or the date the individual would have been eligible for institutional level care (were it not for the penalty period), whichever is later.

The sanction period cannot start until eligibility is determined.

EXAMPLE #1

Applicant/beneficiary transferred \$8947.36 to her daughter on March 9, 2006. On April 3, 2006 she applies for Medicaid, as she needs to go to a nursing home. She does not supply verification of income from a private pension source. Her eligibility cannot be determined; therefore, her sanction period does not start.

EXAMPLE #2

Applicant/beneficiary reapplies on November 5, 2006 for ongoing and retro Medicaid. She now supplies all necessary verification and is determined eligible effective August 1, 2006. However, a sanction period of 2 months is determined based on the March 2006 transfer. ($\$8947.36 \div \$4,473.68 = 2$ months) Applicant/beneficiary's sanction period begins August 2006 and the first month of eligibility would be October 2006. The applicant/beneficiary may be eligible for other programs that do not include long-term care services.

2. If applicant/beneficiary or spouse of an applicant/beneficiary makes multiple transfers on or after February 8, 2006, for less than fair market value during the look-back period, the transferred amounts are added together and one sanction period determined.

The sanction period cannot overlap with a previously determined sanction period.

EXAMPLE

Applicant/beneficiary transferred \$50,000 worth of stocks on March 5, 2006, to his son. On May 10, 2006, he gave his daughter \$15,000 to purchase a new car. On July 1, 2006 he gave his brother \$1,000 and November 5, 2006 he gave his sister \$1,105.20. The applicant/beneficiary applies for nursing home care on November 10, 2006. He supplies all documentation and is determined Medicaid eligible effective November 1, 2006.

The transfers totaling of \$67,105.20, result in a sanction period of 15 months ($\$67,105.20 \div \$4,473.68 = 15$) beginning November 1, 2006. The first month of eligibility would be February 2008. The applicant/beneficiary may be eligible for other programs that do not include long-term care services.

C. Partial Months of Ineligibility Due to Transfers

Previously, policy allowed for the disregard of a transfer penalty if the penalty was determined to affect less than a month. The DRA of 2005 imposes partial months of ineligibility. The effective date of this change is February 8, 2006. The current private pay rate for nursing home care is \$4,473.68 per month. To calculate months of ineligibility, divide the amount of the transfer by the monthly private pay rate of \$4,473.68. Round down the number of days of ineligibility when a partial day of ineligibility exists.

EXAMPLE

An applicant/beneficiary makes an uncompensated transfer of \$30,000 in April 2006, the month he applies for Medicaid coverage of long-term care services. The uncompensated transfer amount of \$30,000 is divided by the average monthly rate of \$4,473.68 and equals 6.70 months. The full 6-month penalty period runs from April 1, 2006, the month of transfer, through September 2006 with a partial month penalty calculated for October 2006. The following steps are used for calculating the period of ineligibility.

$$\begin{aligned}
 \text{Step \#1:} & \quad \$30,000 \text{ uncompensated transfer amount} \\
 & \quad \div \underline{\$4,473.68} \text{ average monthly private pay rate} \\
 & \quad = 6.70 \text{ number of months for penalty period} \\
 \\
 \text{Step \#2:} & \quad .70 \text{ Partial month penalty period} \\
 & \quad \times 30 \text{ 30 days month} \\
 & \quad = 21 \text{ \# of penalty days}
 \end{aligned}$$

For October 2006, the partial month penalty is 21 days. This means that the Medicaid program would authorize vendor payment for long-term care expenses beginning October 22, 2006. The applicant/beneficiary may be eligible for other programs that do not include long-term care services.

III. **UNDUE HARDSHIP WAIVER**

- A. An applicant/beneficiary may claim undue hardship when imposing a penalty period would result in discharge to the community and an inability to obtain necessary medical services so that the applicant/beneficiary's life is endangered.

Undue hardship may also exist if the imposition of a penalty period would deprive the applicant/beneficiary of food, clothing, shelter, or other necessities of life. Undue hardship relates to the applicant/beneficiary, not the relatives, responsible parties of the applicant/beneficiary, or the facility in which the applicant/beneficiary resides. Undue hardship does not exist when the imposition of the penalty causes the applicant/beneficiary an inconvenience or may restrict his lifestyle but not put him at risk for serious deprivation.

- B. Applicant/beneficiary must be notified in writing when a transfer of assets will result in a sanction period. The DHHS 932 ME, Notice of Denial of Waiver Services or Nursing Home Care, must be used to notify the applicant/beneficiary.

Procedure for Waiver of Penalty

While a request for an undue hardship waiver is pending for an individual currently residing in a nursing facility, a payment may be made to the facility for up to 30 days.

The eligibility worker must obtain a letter from a physician verifying such an action would result in a life-threatening situation and one of the following verifications:

- Letter from the nursing home either:
 - Refusing to admit the patient, or
 - Threatening discharge of the patient;
- Letter from CLTC either denying or terminating services

The county must demonstrate that all other possible exceptions to the imposition of the transfer penalty have been explored, including return of the assets to the applicant/beneficiary. Send the letters and other documentation to the DHHS Division of Policy and Planning for evaluation.

If a request for an undue hardship waiver is denied, the applicant/beneficiary may request a fair hearing.

IV. ANNUITIES

The Deficit Reduction Act of 2005 made many changes concerning annuities purchased on or after February 8, 2006.

Procedures for Annuities Purchased on or After February 8, 2006

- At application and review, applicants/beneficiaries must disclose to the agency the existence of any annuities held by the applicant/beneficiary or the community spouse;
- The purchase of an annuity may be treated as a disposal of an asset for less than fair market value unless the SC Department of Health and Human Services (SCDHHS) is named as the primary remainder beneficiary for at least the total amount paid by Medicaid for long-term care services, or is named as such a beneficiary after the community spouse and/or minor or disabled child;
- SCDHHS must inform the issuer of the annuity of the requirement that the agency be named as the primary remainder beneficiary, and the responsibility of the issuer to inform the agency of any change in the amount of income or principal withdrawn from the annuity; and
- An annuity shall be treated as a disposal of assets for less than fair market value unless it is irrevocable and non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

A copy of the annuity must be sent to the Division of Policy and Planning for evaluation.

V. PROMISSORY NOTES, LOANS, AND MORTGAGES

The purchase of a promissory note, loan, or mortgage on or after February 8, 2006, is considered an uncompensated transfer unless the repayment agreement meets the criteria below.

- A. The total value of the note, loan, or mortgage is expected to be paid back in full during the actual or expected lifetime of the lender, and
- B. Repayment is to be made in equal amounts during the term of the note, loan, or mortgage, with no deferral and no balloon payments, and
- C. The agreement prohibits the cancellation of the balance upon the death of the lender.

A promissory note, loan, or mortgage that does not meet all the criteria above is considered a resource. The amount of the resource is the remaining balance owed on the promissory note, loan, or mortgage at the time of application for long-term care.

A copy of the promissory note, loan, or mortgage must be sent to the Division of Policy and Planning for evaluation.

VI. PURCHASE OF A LIFE ESTATE

Count the purchase of a life estate in another individual's home on or after February 8, 2006 as a transfer of asset unless the purchaser resides in the home for a period of at least one year after the date of purchase. Count the entire purchase price as an uncompensated transfer if the purchaser resides in the home for any period less than one year. Determine the sanction period based on the purchase price.

The one-year period must be a total of 12 consecutive months where the person resided in the residence and considered this his/her home. Vacations, overnight visits, and hospital stays should not be deducted from the one-year provided this continued to be the individual's legal residence.

In addition to the above requirement, the purchaser must not pay more than fair market value for the life estate. Any amount paid above fair market value is considered a transfer and should be penalized according to the transfer policy.

VII. CONTINUING CARE RETIREMENT COMMUNITIES

Continuing Care Retirement Communities (CCRC) is sometimes referred to as a "life care community". The service provides multiple residential options in one location. Residential options typically include independent living arrangements, assisted living, and skilled nursing care. Usually, a contract is required that obtains a financial commitment from the aging

person in return for assurances that the appropriate level of care will be provided when needed.

- A. Entrance fees for a Continuing Care Retirement Community (CCRC) or Life Care Community (LCC) is considered a resource at the time of application if:
 - 1. The entrance fee can be used to pay for care should other income or resources be insufficient to cover the cost; or
 - 2. The individual is eligible for a refund of any remaining fee when the individual dies or terminates the contract; and
 - 3. Payment of the entrance fee does not give the individual any ownership interest in the community.
- B. Eligibility workers will need to review admittance contracts from CCRC's and LCC's at the time of application. Based on the contract and the criteria above, the eligibility worker will need to determine if the entrance fee is a resource.

A list of licensed CCRC's can be found at www.sccoconsumer.gov.

Please review this transmittal with appropriate staff. Training and on-line Medicaid Policy and Procedures Manual updates are forthcoming.